



514 N. Locust  
Denton, TX. 76201  
Off: (940) 239.9049  
Fax: (940) 239.0562

## Notice of Independent Review Decision

**DATE OF REVIEW:** 10/29/08

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

MRI of the lumbar spine

### **A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified in Neurology

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

MRI of the lumbar spine - Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Examination Evaluation, M.D., 01/02/08, 02/07/08, 09/08/08, 09/16/08, 10/02/08
- Electrodiagnostic Medicine Consultation, M.D., 04/22/08
- Electrodiagnostic Studies Examination, Dr. 04/22/08

- EMG/NCV Preliminary Report, Dr. 04/22/08
- Adverse Determination, 09/16/08, 10/03/08
- Letter of Appeal, Dr. 09/24/08
- Notice of Assignment of IRO, 10/09/08
- Preauthorization Request (No date)
- The ODG Guidelines were not provided by the carrier or the URA.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient injured his neck, left arm, and lower back on xx/xx/xx. He also had numbness in his right hand. He has undergone treatment for these injuries and an MRI was performed on 04/26/07. Cervical ESI's and lumbar facet injections were also performed and his most recent medications were noted to be Tramadol and Darvocet.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

Based ODG treatment guidelines for a diagnosis of lumbosacral radiculopathy 724.4: A single MRI scan is appropriate for that diagnosis. A subsequent MRI scan would be appropriate if there has been significant neurologic change by physical examination. There is no documentation in the medical records that the claimant has had any new neurologic findings which would support a repeat MRI scan. A primary MRI scan had already been performed on 04/26/07, revealing bulges at L4-5 and L5-S1 with an annular tear on the left at L4-5 and L5-S1 with facet hypertrophy at L3-4 and L4-5 bilaterally. There is no documentation by Dr. of any objective motor deficit supporting the request for a repeat lumbar MRI scan. Dr. only documented increased low back pain, which is not an indication for a repeat lumbar MRI scan according to the ODG treatment guidelines.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM - AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR - AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE  
IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT  
GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE &  
PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL  
LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME  
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**